Appendix 11

Example of a Prior Authorization Request Form (PA/RF) for Personal Care and Home Health Services - Dually Certified Agency

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 120

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider, 10 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654321
10 DX: PRIMARY: 401.9 - hypertension NOS
11 DX: SECONDARY: 250.0 - diabetes II (NIDDM)
12 START DATE OF SOI: N/A
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9931		4	1	HHA initial visit	24	XXX.XX
				1 visit/day X 3 day/wk X 8 wk		
W9903		4	1	PCW	406	XXX.XX
				14 hr/wk X 29 wk		
W9902		4	1	3.5 hr/wk TT X 29 wk	101.5	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY

23 MM/DD/YY (DATE) 24 I M Provider RN (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED
[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

GRANT DATE | EXPIRATION DATE | PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED ***

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the Medicaid professional

DATE | CONSULTANT/ANALYST SIGNATURE

482-120

Appendix